

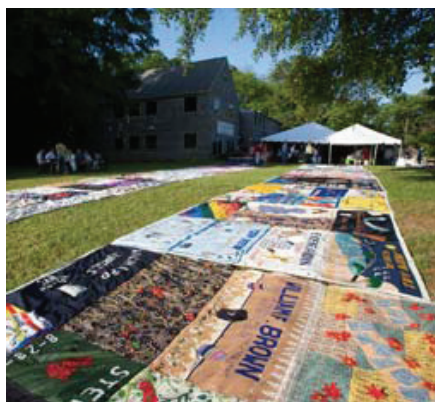
Since the beginning of the HIV epidemic, gay men have been disproportionately affected, and that trend continues today. In 2010, gay and bisexual men were 44 to 86 times more likely to be infected with HIV than their heterosexual counterparts.⁴⁵



Issues

Gay Men

Gay men have been heavily impacted by HIV/AIDS since the beginning of the epidemic. Gay men have helped lead the way towards creating high standards of culturally competent care and integral to the creation and direction of the Ryan White HIV/AIDS Program.



An AIDS diagnosis was likened to a death sentence in the epidemic's early years. The AIDS Quilt, pictured here, was one way to remember those who had lost their battle against the disease.

Gay Men and the History of the Ryan White HIV/AIDS Program

Within that first year, it became apparent that something new was happening, and we were of course, as it turned out, sort of at Ground Zero of the AIDS Epidemic.

—Dr. Jay Dobson, New York-Presbyterian Hospital

It Begins

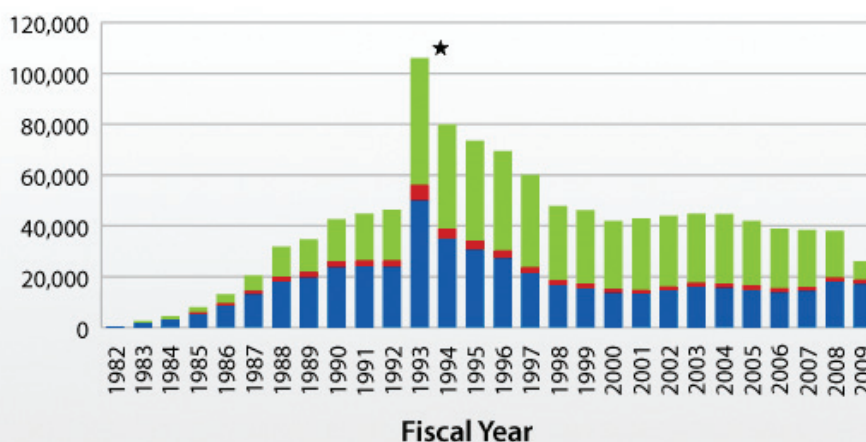
Gay men were disenfranchised sexual minorities and by the late 1970s and early 1980s they began requesting—and requiring—equal rights. This equality became available in some large urban areas especially in New York and San Francisco, affording gay men a new sense of freedom. Gay men flocked en masse to these locales where they could live and love as they chose. The joy of this moment was short-lived.

A disease suddenly began to spread and that, at first, made no sense, seemed to have no clear cause, and had no immediate or direct treatment. In 1980, physicians working in gay enclaves began to see men presenting symptoms of what appeared to be the flu, but often became a deadly case of *Pneumocystis carinii* pneumonia (PCP). Others had rashes on their skin—later diagnosed as Kaposi's sarcoma, a rare cancerous tumor of the connective tissue previously seen most often in older men of Italian or Eastern European Jewish origin.¹ PCP and Kaposi's sarcoma were among the earliest opportunistic infections of HIV disease, though clinicians didn't know it yet. HIV compromises the immune system creating “opportunities” for pathogens to infect and creating a whole host of health issues in HIV-positive persons. So what had seemed like isolated and unexplainable occurrences quickly became something more.

In June 1981, an entry in the U.S. Centers for Disease Control and Prevention (CDC) *Morbidity and Mortality Weekly Report* captured the attention of the medical community the world over:

In the period October 1980-May 1981, five young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at three different hospitals in Los Angeles, California. Two of the patients died.²

AIDS DIAGNOSES AMONG MSM COMPARED TO OTHER GROUPS, 1982-2009*



■ MSM* ■ MSM/IDU** ■ Other

*MSM= men who have sex with men (term used in data source)

**IDU= injection drug users

★ This spike is a result of a change in AIDS definition.

Year	MSM	MSM / IDU	Other
1982	339		63
1983	1,848		814
1984	3,354		1,189
1985	5,391	576	2,127
1986	8,554	954	3,502
1987	13,047	1,438	5,943
1988	17,993	2,055	11,680
1989	19,652	2,138	12,808
1990	23,738	2,295	16,524
1991	23,960	2,366	18,497
1992	23,936	2,429	19,970
1993	49,963	6,098	49,929
1994	34,974	3,853	40,847
1995	30,671	3,425	39,284
1996	27,316	2,967	39,190
1997	21,260	2,374	36,527
1998	16,642	1,984	29,261
1999	15,464	1,806	28,867
2000	13,562	1,548	26,850
2001	13,265	1,502	28,216
2002	14,545	1,510	27,895
2003	15,859	1,695	27,257
2004	15,607	1,696	27,312
2005	14,819	1,742	25,339
2006	13,775	1,603	23,538
2007	14,383	1,514	22,400
2008	17,940	1,729	18,281
2009	17,171	1,608	7,323

*MSM= men who have sex with men (term used in data source)

**IDU= injection drug users

*Source: CDC HIV/AIDS Surveillance Year-end Reports 1982-2008

Even Providers Experienced Stigma for Treating Gay Men

“What’s a nice nurse like you doing in AIDS care working with ‘those’ people?” recalls a Ryan White HIV/AIDS Program-funded nurse when she first transitioned from Oncology to AIDS care. She says, “It was as if I had moved from an honorable sector of nursing to the ‘dirty’ part of health care.”

This was the first official scientific documentation of what would shortly thereafter be termed gay cancer or the gay plague in the media,^{3,4} and gay-related immune deficiency (GRID) by the CDC.^{5,6,7} The illness continued appearing with increasing frequency. The medical community and scientific researchers had no idea how it was spread, or why gay men appeared to be carrying such a disproportionate level of burden of the new disease.

In 1982, the CDC re-named the disease Acquired Immune Deficiency Syndrome (AIDS) to reflect the evidence that it was impacting various populations, including injection drug users, Haitians, and hemophiliacs.⁸ Still there was no question that this disease was claiming the lives of gay men in staggering numbers, as it would for decades to come. At the end of 1983:

- 71 percent of the 3,064 reported AIDS cases were among gay and bisexual men;
- 42 percent of all cases were in New York City, 12 percent in San Francisco, and 8 percent in Los Angeles.⁹

Of course, the story of HIV/AIDS among the gay community is about far more than the numbers. It is the tale of a community jolted by fear, shunned by many, and awakened to its own deep sense of compassion. This story of individual and collective suffering and bravery is inextricably tied to the Ryan White HIV/AIDS Program itself and, of course, the efforts of the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) in launching the first Federal efforts to combat this disease and ensure access to care and services for people living with HIV/AIDS who had nowhere else to turn.

Stigma and its Power

The disease moved quickly through the gay community and brought with it great loss. Gay men questioned why some were getting sick and others were not. Those who were well lived in fear of an emerging rash or cough. Gay men began to find themselves, once again, despised and rejected. There was confusion, panic, and even ostracism within the community itself as the epidemic gained its foothold, but it was nothing compared with the discrimination, hostility, and blatant homophobia gay men were encountering. Some religious leaders called AIDS “God’s punishment.” Some employers fired people who became sick and some families abandoned their AIDS-stricken sons and brothers, many of whom had never told their families that they were gay. Fear and misunderstanding was at work but so was a willingness to disregard basic facts about what was already known at this early stage: HIV/AIDS was not readily transmissible.

So from one epidemic there sprung others—epidemics of isolation and cruelty, epidemics of unmet basic human needs, and of poverty. Many gay men with AIDS found themselves without homes due to unemployment, rising medical costs, and evictions. Stigma and shame kept some from seeking medical care and when they did they were often met with anger, fear, and a lack of compassion.

Some physicians and nursing staffs refused to provide treatment to those with AIDS symptoms. As people died, fear, stigma, and willful ignorance and refusal to deal with the facts at hand, kept many funeral homes from accepting bodies for burial. Obituaries frequently did not mention that the person died of AIDS, or an AIDS-related disease, as family members were too embarrassed to admit this about their son, brother, uncle, or father.

Activism and Action

Reeling from caring for loved ones, friends, and the shock of the sudden and mysterious epidemic, the gay, lesbian, bisexual and transgender (GLBT) communities quickly came to realize that if they didn’t take action, nobody would.



They created organizations like the Gay Men's Health Crisis in New York City in 1981 and the San Francisco AIDS Foundation in 1982. Existing clinics serving the gay community, such as Fenway Community Health Center in Boston, MA; Howard Brown Memorial Clinic in Chicago, IL; and Whitman-Walker Clinic in Washington, DC; started AIDS programs. As cases appeared in other cities, similar efforts emerged. And all the while these were beginning to create models of care that HRSA would later adopt.

These early organized responses to HIV/AIDS relied heavily on those who had or knew someone with AIDS. They focused on piecing together networks of care and support. Volunteers included doctors and nurses willing to treat people with AIDS. Attorneys stepped forward to handle legal issues such as those related to evictions and insurance.

Case managers connected patients to much-needed social services, and volunteer buddies and support groups stood by the abandoned and provided respite for the exhausted families and friends of the sick. The lesbian community, in particular, rallied in support of their gay male friends, sometimes serving as the sole caregivers to the dying. Many of these individuals would eventually become Ryan White providers and grantees as well as HRSA administrators.

"The people I worked with were mostly there for the same reasons I was," said Theresa Fiaño, a bartender and disc jockey at gay Seattle nightclubs in the early 1980s, and an early volunteer in local AIDS groups. "We knew someone who was affected and wanted to do something, whatever we could."

Like many gay men, lesbian women, and their allies, Fiaño went on to work in a community-based organization. "In those first years, it was very much a family of individuals who became professionals who were always committed to the cause of helping people living with their HIV."¹⁰

Volunteers and activities within the gay community helped build the first networks of AIDS care and support by strongly advocating for a robust public response to the epidemic. Need still far outstripped available resources. The needs of persons with HIV/AIDS were growing exponentially with every newly diagnosed case.

The gay community could not on its own build public demand for action and create the political will in Washington to create the large response warranted by the scope of the epidemic.



The gay community lobbied on Capitol Hill for increased funding, research, and prevention efforts and pushed for faster testing and approval processes of prescription drugs.

Care Out of Reach

In 1982, The New York Times estimated the cost of hospital care at \$64,000 per patient.¹¹ The financial burden associated with the disease was overwhelming for people living with HIV/AIDS. Patients were so sick that they spent their days in and out of emergency rooms, doctors' offices, and in hospital beds. The need for medical care and support was constant. People desperate for treatment options used their financial resources to try to find a cure wherever they could, and with whatever rumored medication or treatment they could find.

By 1986, human trials of a drug called AZT (zidovudine) were underway at the National Cancer Institute and at Duke University. The studies showed marked clinical improvements in the patients who received AZT over the placebo and just seven months into the trial, the results were so promising that the unblinded study was halted and indications for the treatment recommendations were created to begin distributing medications outside of the research setting. In March 1987, the U.S. Food and Drug Administration (FDA) approved AZT to treat HIV/AIDS. Once approved, however, the drug's price rose to approximately \$188 per bottle (between \$7,000 and \$10,000 per year per patient depending on individual dosage).¹²

For many men living with AIDS, \$7,000 annual costs of an AZT regimen might as well have been \$7 million. Either because they were fired or simply too sick to work, financially self-sufficient men with HIV/AIDS lost their jobs and their health insurance. Without health insurance, most found the cost of care, including regular doctor's visits and hospitalization with opportunistic infections, out of reach.

The gay community advocated for funding for research, prevention, and care using political influence and networks to work for change. Having learned much about what was needed to care for those living with the disease, they lobbied on Capitol Hill demanding better and affordable health care and successfully pushed for changes in the testing and approval processes for prescription drugs. There were small gains in terms of research dollars and funding for outreach and awareness and they pushed for more. HHS, including HRSA, began to respond even before there was any hope of a sweeping inclusive program but many of HRSA's early initiatives paved the way for, and are subsumed into, the Ryan White HIV/AIDS Program.

These early efforts included HRSA's [AIDS Service Demonstration Grants](#), established in 1986, and awarding monies to Los Angeles, San Francisco, New York, and Miami, cities that had a high proportion of AIDS cases. For these communities, the new resources could not have come soon enough. HRSA continued to add new grantees each year to meet expanding needs.

"We used the AIDS Demonstration Project as a model for building a real health services system," explains Matthew McClain, who worked in HIV/AIDS care in the city of Philadelphia, which was awarded an AIDS Service Demonstration Grant in 1988. "Even though our first year grant was tiny, at the time we just thought it was an incredible victory. It was an amazing, beautiful thing. It had a huge impact on all these organizations and we saw it have an immediate impact on the community."

The AIDS Service Demonstration Grants created a prototype for what eventually became the Ryan White Title I Program, known today as [Part A](#). In FY 2011 there were 56 Part A [recipients](#).

Responding to further need, in 1987 HRSA began the AIDS Drug Reimbursement Program, the precursor to the Part B [AIDS Drug Assistance Program](#)/ADAP, and provided \$30 million in funding to increase access for people who could not afford medication. Those who were not eligible for Medicaid or who lived in States that did not cover AIDS treatment were eligible for the assistance.

Also in 1987, HRSA worked with Congress to create the [AIDS Education and Training Centers](#) (AETCs), originally housed in the HRSA Bureau of Health Resources



Ryan White courageously fought AIDS-related discrimination and helped educate the Nation about HIV/AIDS.

Development. At that time, given the lack of meaningful treatment options, their focus was primarily on support services and death and dying. AETCs work to increase culturally appropriate clinical competency among HIV providers.

In the Spotlight

Though AIDS was one of the biggest public health developments in U.S. history, it received little attention from the media until 1985 when actor [Rock Hudson](#), who had been seeking experimental medical treatment in France, acknowledged that he had the disease. As time passed, other public figures—most famously Elizabeth Taylor—stepped forward as allies and advocates. There were others too, such as Elton John and Michael Jackson, all helping to draw public attention to a roaring stampede of suffering and death. Having straight athletes such as Magic Johnson and Arthur Ashe step forward with their diagnoses also created a positive impact in capturing the media and, therefore, the world's attention about AIDS.

And then, in 1987, a 13-year-old boy with AIDS named [Ryan White](#) came forward. Ryan was a hemophiliac from Kokomo, Indiana, who was infected with HIV through tainted blood product and diagnosed with AIDS in 1984. Ryan had been barred from attending school and his battle to return received international attention. He made numerous media appearances and in 1988 shared his story before the President's Commission on AIDS. Ryan willingly opened up about the discrimination he and his family endured as a result of the fear and panic about his attending school.

Ryan's appearances and testimony did something that those of the thousands of gay men who had died had not been able to do. Because he had contracted the disease through no actions of his own, he put a widely acceptable human face on AIDS. But, as Senator Edward Kennedy would later note, "He never drew a line between himself and other people living with HIV/AIDS and always urged compassion and support for all people living with the disease." Ryan's mother, Jeanne White-Ginder, still speaks of the gay men who reached out to her and Ryan to offer assistance and support while many of those in her own small community—people she had known for much of her life—turned away.

1990: The CARE Act—Increasing Resources, Increasing Responsibilities

At a time when the early community-based response to AIDS, built largely by the gay and lesbian community, was stretched to its limits, HRSA provided a critical influx of resources and support. It was 1990, the year Ryan died, that Congress passed the Ryan White HIV/AIDS Comprehensive AIDS Resources Emergency (CARE) Act and President George H.W. Bush signed it into law. Today it is known as the Ryan White HIV/AIDS Treatment Extension Act or, more simply, the Ryan White HIV/AIDS Program.

Also in 1990, the CDC reported 94,125 cumulative AIDS cases among gay men in the U.S, including 10,557 gay men who were also injection drug users.¹³

Cities were under siege and States and rural communities desperately needed the resources and structure the Ryan White CARE Act brought. Gay men became involved in its implementation or, in the case of the HRSA AIDS Services Demonstration Grants, involved in program expansion. In short, gay men were working at every level and every way imaginable, and continue to do so today.

HRSA gives grants to organizations, many of which employ gay men to help implement their Ryan White programs. They fill leadership and administrative roles at the Federal, State, and local levels—and inside public and private agencies. HRSA created ways to ensure programs were reflective of the people they serve. This can be seen in the creation of Planning Councils (commissions delegated to identify service needs and gaps, develop plans for HIV delivery, and establish priorities for funding allocation), and consumer advisory boards (organizational boards comprised of HIV-positive individuals who help advise clinics on HIV care delivery), many of which include gay men.

Gay men work as case managers and outreach coordinators, as doctors and nurses, as advocates and planners, as developers of evermore effective programs and in



Consumers have continued their strong involvement in the Ryan White HIV/AIDS Program, ensuring their representation on Planning Councils, Consortia, and pushing providers to create consumer advisory boards.



Gay men of color are at greatest risk of HIV but less likely to identify as “gay” than are White men, posing additional barriers to prevention messaging.

many other ways that were completely unfathomable at the onset of this strange new disease. And it should always be remembered that they have often made their professional contributions at significant cost: the field of HIV/AIDS was never a “safe” place to work, often being perceived as a stigmatizing dead-end career choice. More personally for gay men, working in the field of HIV/AIDS frequently resulted that they had to come out from the safety of the closet, exposing them to the risks faced by their HIV-positive clients: being ostracized, abandoned, and scorned.

As the Ryan White CARE Act came into being, it immediately became “a lifeline for communities across the country,” says Phill Wilson, AIDS coordinator for the City of Los Angeles at the time. Wilson, a gay man, who today is Chief Executive Officer of the Black AIDS Institute, was the first co-chair of the Los Angeles Eligible Metropolitan Area (EMA) Title I Ryan White Planning Council.

Wilson recalls how the new CARE Act opened doors to medical care for those who did not meet Medicaid eligibility criteria. He reminds us that the new legislation provided critical wraparound support programs that Medicaid and other public programs did not cover. These support services, according to Wilson, “facilitated some people hanging in until the advent of HAART [highly active antiretroviral therapy].”

“The Title I program changed the way AIDS services were provided in the community,” says Seattle’s Fiaño. She worked for the EMA’s Planning Council and later became manager for the EMA’s Title I program. Because of the new program, “we did a lot of things that we’d never done before,” she said. These included such things as conducting needs assessments; client surveys; focus groups; and community forums. Activities like these underline the program’s consumer orientation and HRSA’s continued emphasis on responding comprehensively to clients’ needs.

“People were in and out of hospitals,” Fiaño reminds us. “We provided a lot of case management and home health care.” It is impossible for people who came to know the epidemic in America after the advent of HAART to fathom the breadth of suffering, pain, and death. During the first six years of the Ryan White HIV/AIDS Program (1990-1995), it is estimated that nearly 325,000 gay men died of AIDS in America.¹⁴ HIV care providers talk of those years of being a period of soaring infections and constant death—of going to a Planning Council meeting and seeing the empty chair of a recently deceased community member.

As the Ryan White HIV/AIDS Program grew in the early years, it helped build systems of care that did not previously exist. For example, in Atlanta, Grady Hospital was (and still is) the largest provider of care to the poor in the region. When the Ryan White HIV/AIDS Program was enacted, the hospital had a five- or six-month wait for appointments. With new financial resources from HRSA, the EMA’s Planning Council developed a triage system to unburden Grady Hospital by funding local health departments and agencies like AID Atlanta and St. Joseph’s Health System who would see clients, ultimately reducing their wait time to a couple of weeks.¹⁵

Across the country, new service providers emerged, and more established groups were able to add new services. In the first five years of the Ryan White Program, HIV/AIDS spending through HRSA increased from \$220.6 million in 1991 to \$633 million in 1995. Through collaboration and planning, stronger care infrastructures developed and as time passed they became increasingly competent at serving people living with HIV/AIDS. “I think we are successful because we are accountable to the populations that we are supposed to be serving,” says Seattle’s Fiaño.

Beyond the Epicenters: Reaching Gay Men in Smaller Towns and Rural Areas

While HIV/AIDS emerged in urban America it did not stay there, and gay men living outside these cities faced unique barriers to care. Among the most obvious was that

of distance. Those with access to transportation and living in close proximity to a large city could access care with the frequent added benefit of receiving care with the anonymity that large urban areas provide. But not everyone could travel and even for many who could, urban areas were simply too far away.

Other factors confronted gay men living in smaller cities, towns, and rural areas. Bigotry and homophobia had driven tens of thousands of gay men to cities for decades. Gay men living with HIV/AIDS in rural areas were silenced and isolated by the stigma attached to both their gayness and their HIV infections. Depth of education in clinical treatment of HIV disease and the comparatively lower incidence rates limited both the quality of care and the breadth of services. HRSA's Title II (Part B) grants to States and U.S. Territories and the Title III (Part C) Early Intervention Services (EIS) program began to address these problems. The Part B State grants and the Part C EIS grant did not exclusively target urban centers, helping to ensure the services were available to gay men living in less heavily populated areas. [Low Prevalence Planning Grants](#), however, specifically directed funds for HIV care and services outside traditional epicenters.

The importance of HRSA's AETCs in increasing culturally competent clinical care capacity in not only rural areas, but across the entire country cannot be overstated. Over the Ryan White HIV/AIDS Program's history, more specific initiatives have been undertaken to expand access to and improve the quality of HIV care in rural parts of the country.

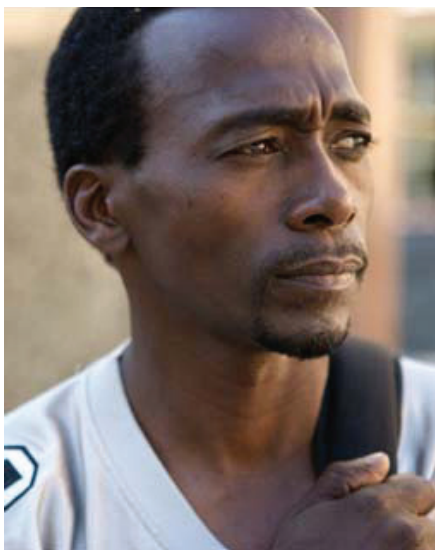
In the mid-1990s, the University of Vermont, for example, developed a model of care for serving the State's dispersed rural population by decentralizing care from a single large site and opening three additional small clinics in small regional hospitals that were initially funded by a [Special Projects of National Significance](#) (SPNS) grant. Each of the clinics is staffed by a part-time, HIV-trained nurse practitioner and a part-time social worker; a physician travels to each of the clinics once-a-month and is in contact with them weekly. After the initial grant ended, the program began receiving funds from Title II (Part B) and Title III (Part C). "Without those funding streams these clinics wouldn't exist. I don't know what those people would be doing or what their level of care would be," said Dr. Christopher Grace, who created and leads the initiative.¹⁶

In 2006, the Wyoming Rural AIDS Prevention Project piloted a peer-led, Internet-based intervention for rural gay men in which two gay men (one HIV positive and one HIV negative) discuss HIV prevention strategies in online communities. The project's results demonstrated an increase in knowledge, safer sex practices, and self-efficacy among





Breakthroughs in HIV testing, monitoring, and treatment have significantly reduced HIV-related morbidity and mortality among gay men—and for all people—living with HIV disease in the United States.^{46,47,48}



Gay men account for an estimated 2 percent of the U.S. population⁴⁹ but 47 percent of AIDS diagnoses.⁵⁰

respondents.¹⁷ Support for rural providers was augmented further through a provision in the 2000 reauthorization of the Ryan White HIV/AIDS Program legislation that gave preference to providers in rural and underserved areas for Title III funding.

The HAART of the Matter

In June 1995, the FDA approved an open label study of saquinavir, a protease inhibitor. The drug—targeting a cell’s protein needed by HIV to replicate itself—marked so substantial a breakthrough in HIV treatment that just six months later the drug was approved by the FDA.

HHS along with HRSA worked to quickly disseminate saquinavir over the course of the following year. Their efforts resulted in an almost immediate drop in AIDS morbidity and mortality in the U.S. To increase access to this miracle drug, which created the first “combination therapy” known as HAART, HRSA used ADAP and its funding mechanism through State health departments. In 1996, ADAP was funded at \$52 million, and by 1997 had increased to \$167 million, marking a significant influx of new resources HRSA made available with which to treat people living with HIV/AIDS.

These efforts had an enormous impact on the gay community who were suffering significantly disproportionate rates of HIV/AIDS. HAART meant patients could suppress HIV replication and restore and maintain their immune function. It provided a kind of renewed dedication to the cause and created a sense of hope throughout the gay community. It meant that HIV/AIDS was no longer a death sentence, and it marked another significant milestone in the fight for HIV not only in resources but in improved care, more effective treatment, and in 1998, it also meant a guide.

Guidelines on HIV treatment had been released in association with widespread adoption of HAART and in April 1998, the U.S. Public Health Service issued more comprehensive, evidence-based HIV [treatment guidelines](#) to address crucial questions, such as when to start HIV treatment, which agents to start with, which to avoid, and what shortcomings exist for antiretroviral therapy. HRSA worked diligently with local providers to get this information into their hands and coordinate associated trainings, many of them through AETCs.

These guidelines are regularly updated as our understanding of HIV and its treatment expands. As providers and researchers became more familiar with HAART, emphasis also turned to medication adherence and side effects.

The gay community continued to be integral in these efforts, both within the government and within clinics, on consumer advisory boards, and in their own neighborhoods. The continuum of care gay men had worked so hard to put in place was still there and was what allowed HRSA to make such a seamless integration of research findings into actual practice. And while gay men recognize the importance of HAART in curtailing the spread of HIV, they maintain a voice for the slew of support services they worked so hard to instill during those early years.

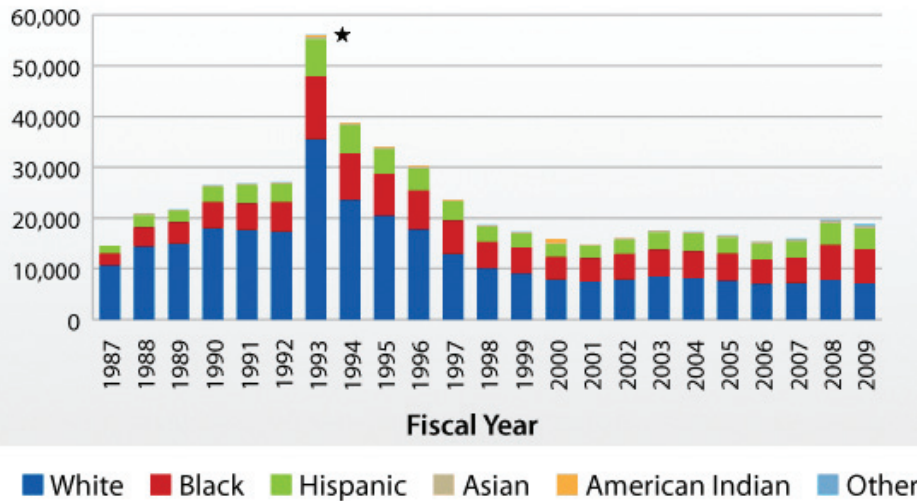
AIDS and Gay Men of Color

From the beginning of the epidemic gay men of color were disproportionately impacted by HIV/AIDS, and by the time the Ryan White HIV/AIDS Program launched in 1990, they accounted for approximately 30 percent of reported cumulative AIDS cases.¹⁸ The AIDS rate among Black men that year was 92.4, or more than 3 times that among White men.¹⁹

Today men of color account for more than 60 percent of all new AIDS cases among gay men,²⁰ and young Black gay men (ages 13 to 29) are experiencing the greatest number of new HIV infections than any other age or racial group of gay men in America.²¹

Though the AIDS epidemic among minorities in America did not begin to see wide scale attention from the general public until the 1990s, gay men of color have always

MSM/MSM-IDU AIDS DIAGNOSES BY RACE/ETHNICITY**



*MSM= men who have sex with men (term used in data source)

**IDU= injection drug users

★ This spike is a result of a change in AIDS definition.

Year	White	Black	Hispanic	Asian	American Indian	Other
1987	10,618	2,392	1,405			119
1988	14,354	3,765	2,360	360	46	3
1989	14,944	4,230	2,232	177	41	41
1990	17,920	5,199	3,029	209	53	63
1991	17,591	5,300	3,588	210	60	65
1992	17,308	5,836	3,511	233	88	52
1993	35,484	12,380	7,372	533	223	69
1994	23,526	9,210	5,504	395	125	67
1995	20,433	8,261	4,883	345	131	43
1996	17,719	7,689	4,386	329	110	50
1997	12,865	6,646	3,722	241	98	62
1998	10,009	5,248	3,054	194	69	52
1999	9,001	5,127	2,855	173	79	35
2000	7,831	4,491	2,502	168	83	35
2001	7,427	4,605	2,433	195	88	19
2002	7,874	5,054	2,793	222	96	16
2003	8,472	5,247	3,365	273	108	89
2004	8,129	5,244	3,505	244	93	88
2005	7,619	5,327	3,177	253	82	130
2006	6,983	4,835	3,103	242	84	131
2007	7,201	4,957	3,223	226	86	204
2008	7,726	6,909	4,300	368	121	245
2009	7,118	6,741	4,136	277	101	408

*MSM= men who have sex with men (term used in data source)

**IDU= injection drug users

**Source: CDC, HIV/AIDS Surveillance Year-end Reports 1987-2009

been involved in and served by the Ryan White HIV/AIDS Program.

Ernest Hopkins, who was working with the community based organization Best Friends of D.C. when the Ryan White HIV/AIDS Program was enacted and today works for the San Francisco AIDS Foundation, recalls that, early on, care for Black gay men was heavily focused in poorer areas of D.C.

Washington DC's Black gay community had "hit the wall in 1989 and 1990," says Hopkins. "We started to see a flood of people who had been infected for a while and were really sick." Hopkins says that treatment with AZT was "terribly taboo" in the Black community at the time, in part because of misinformation being spread by people who disputed both the cause of HIV/AIDS and the cures they were peddling.

Just as many White gay men had encountered in their communities, many health care providers in the African-American community at the time did not see it as their role to care for people living with AIDS and would refer them elsewhere.

The uninsured relied on emergency rooms and "the stigma was so strong they were almost dead before they would take help," recalls Hopkins.

Accessing HIV/AIDS services for some gay men of color has historically been made challenging by social, economic, and cultural barriers to care. It has, for example, been repeatedly documented in the literature that many minority gay men did not at the onset of the epidemic (and do not today) identify as "gay" men. These men are frequently identified as "men who have sex with men" or abbreviated MSM by epidemiologists, researchers, and prevention and outreach workers. Fear of being seen going into a site that serves predominantly gay men, has created barriers for some in accessing services. Compounding this issue, gay men of color—and communities of color in general—have historically suffered disparities in access to health care and, as a result, poorer health outcomes. Thus,



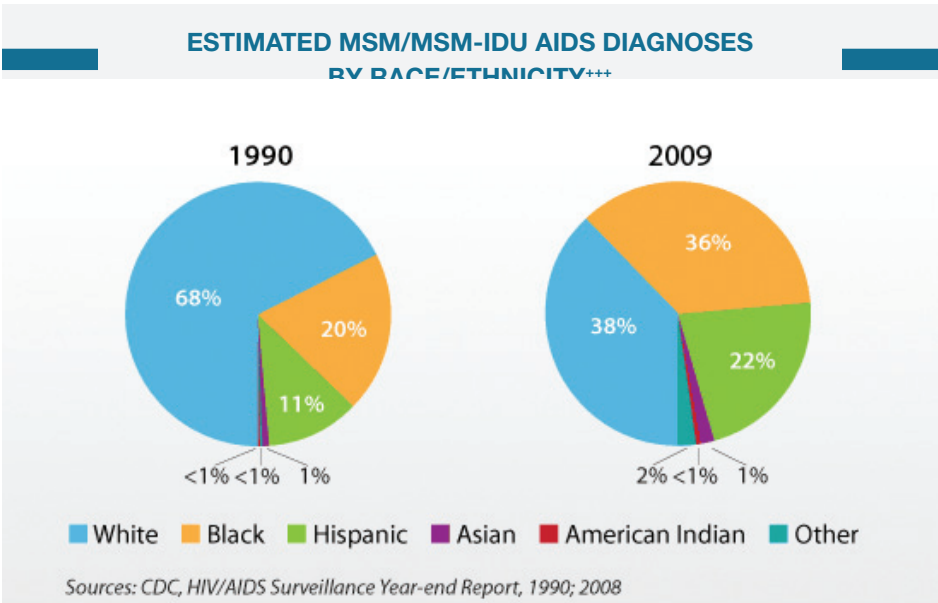
HRSA launched a SPNS initiative from 2004–2009 to address the increasing HIV rates among young gay men of color.

they have been less likely to receive preventive health care or to have an ongoing relationship with a clinical services provider. There are many cultural barriers, too, the most obvious one being perhaps lack of language services available at some locations for Latino gay men.

Just as approaches designed to address the unique needs of White gay men often needed modification to work for women, injection drug users, or heterosexual men, the same was true for minority gay men. And HRSA has worked to build programs and initiatives that reflected the needs of gay men of color.

HRSA made significant efforts in the early years of the Ryan White HIV/AIDS Program to acquire the cultural competency to serve gay men of color. As time passed, organizations took steps to diversify their staffs—including HRSA’s HIV/AIDS Bureau, when it was made responsible for implementing the Ryan White HIV/AIDS Program in 1996. Grants were awarded to expand capacity within minority-serving communities, and providers of HIV/AIDS care built relationships with minority community based organizations in order to reduce the very high number of minority gay men who were not in care.

Despite all these efforts, the AIDS rate among African-Americans and Latinos remained extraordinarily high. Even after HAART was introduced, AIDS mortality rates for minorities did not fall as significantly as they did for Whites. As the end of the Ryan White HIV/AIDS Program’s first decade approached, the scope of the epidemic among minorities called for greater resources, more public attention, and further action.



*MSM= men who have sex with men (term used in data source)
 **IDU= injection drug users

Year	White	Black	Hispanic	Asian	American Indian	Other
1990	17,920 = 67.69%	5,199 = 19.64%	3,029 = 11.44%	209 = 0.79%	53 = 0.20%	63 = 0.24%
2009	7,118 = 37.91%	6,741 = 35.89%	4,136 = 22.02%	277 = 1.47%	101 = 0.54%	408 = 2.17%
*MSM= men who have sex with men (term used in data source)						
**IDU= injection drug users						
+++Source: CDC, HIV/AIDS Surveillance Year-end Report, 1990; and CDC, HIV/AIDS Surveillance Year-end Report, 2009						

The Minority AIDS Initiative

The Ryan White HIV/AIDS Program was working on its own to reposition resources toward minority needs and in 1999, Congress created the [Minority AIDS Initiative \(MAI\)](#). The new initiative provided a framework for a more comprehensive, coordinated, and strategic response to AIDS in communities of color. The multitude of Federal agencies involved included HRSA's HIV/AIDS Bureau, the CDC, the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Minority Health, and the Office of Women's Health.

“Activists from cultural associations and national organizations had an impact on this work and HRSA valiantly strived to deal with a lot of issues related to HIV including culture,” explains Lucy Bradley-Springer, Ryan White grantee and AETC faculty member. “What happened in the early days, is people stood up and said this is what’s important to my community and myself... and HRSA and Federal legislators paid attention. They listened and incorporated these concerns into various funding streams.”

The MAI has brought significant financial resources to the challenge of addressing AIDS in communities of color. It has also helped to focus much-needed public attention on the social determinants and resulting health disparities fueling HIV incidence among persons of color in the United States. The MAI, through HRSA's leadership, has worked to improve care in minority communities, better training for providers, more targeted prevention messaging, and approaches designed to meet the unique needs of people of color. MAI [grew](#) from \$156 million in 1999 to \$398.7 million in 2005 before being codified into the law in 2006; today its funds are distributed via Ryan White HIV/AIDS Program Parts.

Education & Training

Since 1987, clinical care providers that predominantly serve minorities have taken advantage of extensive training provided by the HIV/AIDS Bureau's AETCs. In 1999, the AETC program's role in addressing the training needs of clinical providers in minority communities was enhanced by creation of The National Minority AETC. The role of the National Minority AETC is to work with the schools of medicine of historically Black colleges and universities to provide clinical consultation. The National Minority AETC builds networks among clinicians and expands educational resources to increase the number of minority clinicians providing quality HIV care.



[When providers are culturally competent, patients are more likely to be retained in care.](#)



In September 2010, two new AETCs were launched to specifically address access to quality care among minorities and replaced the one National Minority AETC. They include the [National Multicultural Center](#), which is committed to improving cultural competency among HIV care providers across the country, and the [National Center for HIV Care in Minority Communities](#), which is implementing exciting new programs that increase HIV care capacity in health centers and should be adding new resources on gay men of color shortly.

There is, of course, a [national AETC](#) as well as regional AETCs to increase training and clinical and cultural competency among providers. As Bradley-Springer explains,

The AETCs are one of the best ways for providers to address cultural issues and offer services to everyone. HRSA, through the Ryan White HIV/AIDS Program, says you are a valuable person and you deserve services...and [it tells providers] your patients are unique, valuable individuals and it doesn't matter what community they come from. AETCs work with providers to develop the skills they need to treat the populations they propose to reach and serve.

[Reaching Gay Men of Color: Special Initiatives.](#)

Effective programs must provide culturally competency care to treat not only physical symptoms of HIV disease, but also meet their clients' particular social and psychological needs.²² Ongoing disparities in HIV treatment outcomes and challenges related to linking and retaining gay men of color in care point to the need for continued efforts to develop and implement more effective strategies.²³

The alarming infection rates among young minority gay men, especially young African-American men, have heightened the need to develop specific and effective programs for this community in particular. "What people miss among populations most impacted is the cumulative effect of various stigmas," said Wilson.

Wilson explained that young, gay, Black men with HIV may feel discriminated against as a person of color and as a sexual minority. They may also feel marginalized within the gay community because they are Black and within the Black community because they are gay. On top of all of this is the stress that HIV stigma continues to carry, particularly within communities of color.

Looking to find models of care that address these challenges, HRSA's SPNS program funded eight demonstration projects under the Outreach, Care, and Prevention to Engage HIV Seropositive Young MSM of Color [initiative](#) to create innovative models of reaching target populations who are not currently in care and linking them with ongoing primary care, support, and prevention services. SPNS programs create replicable models so that HIV providers across the country can learn from these projects and adapt them to their own practices, thus expanding the reach of such programs and furthering efforts among minority gay men.²⁴

[Evolving Epidemic Requires Continuing Innovation](#)

The community of gay activists and supporters has always played a role in shaping the services, care, and support provided by the Ryan White HIV/AIDS Program. These committed individuals help the Ryan White HIV/AIDS Program respond to the evolution of and changes in the epidemic among gay men. Thirty years into the epidemic, many older gay men living with HIV are facing AIDS and treatment fatigue, which can significantly impact their mental health, treatment adherence, cognitive function, and sexual practices. Difficulty sustaining treatment over a long period may be heightened by isolation or depression, loss of social supports, drug side effects, and changes in physical appearance.^{25,26,27} A HRSA SPNS project supported research evaluation of 12 innovative clinic-based adherence models for a variety of populations and provided data about adherence support programs that maximize the benefits of HAART and should be incorporated into routine HIV medical care.²⁸ [Adherence support and counseling](#) is now one of the core clinical HIV performance measures that HRSA encourages grantees to include in their quality management plans.

Surveillance Data: HIV/AIDS and Gay Men

Today, more than one-half of the more than 1.1 million Americans living with HIV/AIDS in the U.S. are gay men, and the rate of new HIV diagnoses among this population is 44 times that of other men and 40 times that of women.

HRSA continues its commitment to serving this population and, just as in those early days of the epidemic, gay men continue to be pivotal in implementing HRSA's Ryan White HIV/AIDS Program.^{43,44}

Adherence challenges, of course, are in no way limited to older gay men. These challenges are also an issue for some younger gay men, who may face many of the same mental health challenges and ongoing access to care. For both older and younger gay men, recreational substance use can be an important determinant of treatment adherence or non-adherence. The drug that has had the most dramatic impact on the gay community in recent years as related to HIV is crystal methamphetamine (meth), which causes the brain to release approximately 1,200 to 1,300 units of dopamine (more than the body can create naturally from any rewarding activity).^{29,30} Additionally, meth is relatively cheap, has a long half-life (typically 9 to 12 hours), creates sexual arousal, and produces a rapid high when ingested by smoking, nasal, or injection routes, making it highly addictive.^{31,32,33}

Use of crystal meth is 5 to 10 times more common among urban gay, bisexual, and transgender persons than among the general U.S. population and is associated with risky sexual behavior; increased rates of transmission of HIV, other STDs, and hepatitis; serious adverse events; and poor adherence to antiretroviral treatment.^{34,35} Ironically, the constricting of blood vessels due to meth can cause temporary impotence and lead to use of sexual enhancement drugs like sildenafil (Viagra), tadalafil (Cialis), or vardenafil (Levitra), something that's become very popular in the gay community.^{36,37} Constricted blood vessels, however, can lead to increase tearing of the skin during sex and thus increase HIV risk.

Additionally, gay HIV-positive men may be at risk for drug interactions if taking meth. Meth's interaction with the HIV protease inhibitor ritonavir, for example, can result in a 3- to 10-fold increase in meth levels in the bloodstream. Ritonavir prolongs the meth high by increasing absorption and decreasing the metabolism of meth and therefore can cause increased toxicity and potentially severe reactions or overdose.^{38,39} Delavirdine, a nonnucleoside analog reverse transcriptase inhibitor, also slows the metabolism of meth.⁴⁰

HIV-infected gay men report using meth as a way to deal with survival guilt, internalized homophobia, and prejudice. Many HIV-positive meth users also cite using meth to counter fatigue and other side effects of antiretrovirals. Treating HIV-positive meth users requires intensive collaboration among mental health specialists, dentists, pharmacists, social workers, primary care physicians, substance abuse counselors and, in some cases, correctional employees. Meth use has been a growing focus of Ryan White grantees and providers as the crisis has increased.⁴¹ HRSA's AETCs have conducted [trainings](#) on the topic and HRSA focused on meth for an issue of their *HRSA CAREAction newsletter*.

The increase of risky sexual practices among meth users is just one example of why the Ryan White HIV/AIDS Program has put increasing emphasis on prevention with all HIV-positive gay men. Other indicators such as rising STD rates in certain communities, treatment optimism after initiation of HAART, HIV prevention fatigue, extended and healthier lifespans for people living with HIV, all contribute to the need for integrating HIV prevention into the clinical care.⁴²

Looking Ahead

HRSA's Ryan White HIV/AIDS Program grew out of the response that the gay community created in the first decade of the AIDS crisis. Since the early 1980s, the program's committed and experienced leadership has become a lifeline for thousands of gay men nationwide. Without the services of the Ryan White HIV/AIDS Program, many gay men and others living with and affected by HIV/AIDS would have perished. As science and research continue to work towards developing new treatments and hopefully finding a cure for AIDS one day, HRSA and its grantees will continue to work to improve the health and wellbeing of gay men living with HIV disease.

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